Employee Benefits Handbook

General Information

The State Personnel Department Benefits Division is responsible for employee statewide benefit programs including health, dental, vision and life insurance. However, you should understand that the Benefits Division does not make any medical determinations related to your claims. All claims are handled through a third party administrator (TPA) or insurer. The contact information for the TPA and insurers can be found on the State Personnel Department's Benefits Division Web site (http://www.in.gov/spd/2337.htm). Listed below is the contact information for the Benefits Division.

State Personnel Department
Benefits Division
402 W. Washington St., Rm W161
Indianapolis, IN 46204
(317) 232-1167
(877) 248-0007
http://www.in.gov/spd/2337.htm

Disclaimer

The material contained in this handbook is for informational purposes *only* and is not a contract. It is intended to highlight the eligibility requirements for the insurance plans, as well as explain the rules governing benefits. If there is any difference between this information and any applicable state or federal law, the law governs. Additionally, should there be a difference between any oral representation provided and any state or federal law, the law governs. It is your responsibility to read all materials provided in order to fully understand the provisions of the option selected.

For questions or concerns regarding:	**Contact:**
Eligibility Enrollment Qualifying events Self Service benefit enrollment General benefit information	**State Personnel Benefits Division** 317-232-1167 877-248-0007
Claims Covered services ID cards Provider networks Prescription drug coverage Provider web sites	**Anthem** 877-814-9709 **Welborn** 800-521-0265 **Delta Dental** 800-524-0149 **EyeMed** 866-939-3633 **American United Life** 800-673-3216 **Key Benefit** 800-558-5553 **Tower Bank** 888-472-8697

Employee Responsibilities

Read all the information carefully

It is your responsibility to become familiar with your benefits plans. It is also a good idea to know what services are covered. You should direct your benefits questions to the State Personnel's Benefits Division or to the appropriate TPA or insurer. All plan summaries and descriptions are available on the Benefits Division Web site.

Plan your decisions wisely

Compare all of your insurance options and determine which option will best suit the needs for you and your family.

Determine the amounts that will be deducted from your paycheck. After you have made your selections at the time of your employment/re-employment, changes can only be made during the annual open enrollment or if you experience a qualifying event.

Verify that your insurance deductions are correct

Enrolling in Self-Service Benefits through PeopleSoft® will provide you with a benefits confirmation statement showing a summary of your elections. Be sure to print and review your confirmation and make sure all your elections are correct. Review your first paycheck and make sure all your deductions are correct. If you notice any discrepancies, contact the State Personnel's Benefits Division. If there is a discrepancy in your benefits deductions, appropriate action will be taken to ensure that your deductions are correct.

Eligibility

Employee eligibility

There are no pre-existing condition limitations for any of the state's plans. All active full-time employees and elected or appointed officials are eligible to participate. For the purpose of benefits eligibility, full-time employees are defined as active employees whose regular work schedule is at least 37 ½ hours per week. The following employees are not eligible for insurance: those whose regular work schedule is less than 37 ½ hours per week and those appointed to intermittent or temporary positions.

Eligibility for life insurance

Upon your employment/re-employment, you are in your initial enrollment period for life insurance. During your initial enrollment period, you may elect any level of life insurance coverage offered for you and your dependents. After the initial enrollment period, you may apply for coverage. However, any amount of coverage requested during this event will require Evidence of Insurability documentation prior to approval. Submitting Evidence of Insurability paperwork does not guarantee approval of life insurance coverage.

Dual coverage

When a husband and wife are both employed by the state, both employees cannot carry family coverage. Married state employees have the following options:

- Both may carry single coverage
- Both may be covered by one family plan or
- One employee may carry family coverage and the other single, but the spouse with single coverage cannot be covered under the family plan.

In the case where two state employees share the same dependent, only one state employee may cover the dependent under health, dental and vision insurance. Dependents cannot have dual coverage. The only exception to this is dependent life insurance.

Eligible dependents

Dependents of eligible employees may be covered under the state's benefit plans. Dependents are defined as:

Spouse: One's wife or husband. An ex-spouse is not eligible for coverage even if court ordered.

Children: Unmarried dependent natural-, step-, foster-, legally adopted- children or children who reside in the employee's home for whom the employee or spouse have been appointed legal guardian.

Age limitation: Dependent children are eligible for coverage through the end of the calendar year of their 19th birthday.

- If the dependent child is a full-time student enrolled in an educational institution, the dependent child may be covered until the end of the calendar year of his/her 23rd birthday.
- If the dependent child is both:

1. incapable of self-sustaining employment by reason of mental or physical disability,

and

2. is chiefly dependent upon the employee for support and maintenance prior to age 19,

then such child's coverage can be continued beyond the limiting age of 19 if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the dependent will continue until the employee discontinues his/her coverage or the disability no longer exists. A dependent child of the employee who attained age 19 while covered under another health care policy and met the criteria specified above, is an eligible dependent for enrollment so long as no break in coverage longer than 63 days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires annual documentation from a physician after the child's attainment of the limiting age.

Examples of persons NOT eligible for coverage as a dependent

- Ex-spouse
- Same sex partners
- Live-in boyfriends or girlfriends
- Parents or parents-in-law
- Grandchildren (unless employee is the court-appointed legal guardian)
- Married children
- Adults under guardianship of employee
- Dependents age 19-23 not enrolled as a full-time student
- Dependents older than 19 that are not disabled
- Any other members of your household who do not meet the definition of an eligible dependent

Penalty for dishonesty

Falsifying information/documentation in order to obtain/continue insurance coverage is considered a dishonest act and could lead to discipline and criminal prosecution. Inadvertent or negligent failures to update or correct information related to eligibility of the employee or listed dependents are also subject to penalty. Employees are responsible for updating dependent information within 30 calendar days of the occurrence of any event affecting eligibility; for example, a divorce severing a marriage or a dependent marries. The state will impose a financial penalty, including, but not limited to, repayment of all insurance premiums the state made on behalf of the employee and/or dependent and any claims paid by the insurance companies. Disciplinary action up to and including dismissal may also be imposed if appropriate.

Enrollment

Enrolling at hire

Health care coverage begins four days after your first payroll deduction. Per the state's contracts with the carriers, elections must be made and submitted no later than the Monday following the pay period in which you were hired. If your elections are not submitted by the deadline, your next opportunity to enroll will be during the annual open enrollment period. Different rules apply to elected officials. Elected officials and legislators must enroll by January 31 of the year following their election/re-election.

Enrolling/making changes during open enrollment

Open enrollment occurs every year and is usually held around November. During open enrollment, you are given the opportunity to make changes to your current elections, add or drop dependents and enroll in coverage. All changes made during open enrollment become effective on January 1 of the following year.

To make changes during the open enrollment period, you must log onto PeopleSoft® and complete the open enrollment process within the designated time frame. Once the deadline has passed, you will not be able to make changes to your benefits until the next open enrollment. The exception is if you have a qualifying event, sometimes referred to as a family status change or life event.

Enrolling/making changes due to a qualifying event

If you have a family status change, you must call and notify the Benefits Hotline within 30 days of the qualifying event. Documentation to support your family status change must also be submitted within 30 days of your notification to the Benefits Hotline. It is important to note that a qualifying event will not allow you to change the plan that you are currently enrolled in but will allow you to change your level of coverage.

A qualifying event may include, but is not limited to, the following:

- Change in legal marital status – Marriage, divorce, legal separation, annulment or death of a spouse
- Change in number of dependents – birth, death, adoption, placement for adoption, award of legal guardianship
- Change in employment status of the employee's spouse or employee's dependent – termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence which results in employee/dependent becoming ineligible for coverage

- Dependent satisfies or ceases to satisfy eligibility requirements – marriage of a dependent or change in student status
- If you move outside your insurance carrier's service area during the benefit year

Effective date of change

The effective date of the change is based on the type of qualifying life event and your previous health coverage at the time of the event. Depending on your specific situation the coverage would change on the date of the event, four days after your first deduction, or 18 days after your last deduction.

Federal Internal Revenue Code (IRS) Irrevocability Rule - Limitations on enrolling/making changes - Penalties

Employee payroll deductions for insurance premiums enjoy tax-exempt status under Section 125 of the IRS code. Plans with tax exempt employee contributions are prohibited from allowing changes in coverage: (1) except during one annual enrollment period; or (2) when the employee experiences a qualifying event. These limitations on enrollment and changes are strictly enforced because the state could lose its special tax treatment for failure to strictly enforce these limitations. Individual employees may be subject to IRS audit which could result in payment of additional taxes and/or other penalties.

This irrevocability rule applies to both increases and decreases in coverage, such as adding or dropping dependents from the health coverage or increasing or decreasing employee life insurance coverage. If you have a qualifying event, and fail to make the relevant changes in your coverage within 30 calendar days, you are prohibited from making those changes until the next annual open enrollment period. Consequences of that failure include loss of coverage for otherwise eligible dependents that were not added within the time limit and/or penalties. This can include disciplinary action or prosecution, for failure to remove ineligible dependents within the time limit.

Medicare

When you turn age 65, you become eligible to enroll for Medicare benefits. If you wish to enroll, you should contact your local Social Security office within one month of reaching age 65. However, you may also decide to delay enrollment in Medicare until your coverage under the state of Indiana group health plan terminates. Once you are no longer covered under the group health plan, you may enroll in Medicare without premium penalty. You will need to elect coverage within a seven-month enrollment period beginning with the first day of the first month in which you are no longer enrolled in a group health plan.

Coordination of benefits

If you are enrolled in both a state health plan and Medicare, the state health plan will be the primary carrier and will pay first. Medicare will be the secondary carrier and will pay toward any remaining balance. If you are enrolled in Medicare only, Medicare will provide your primary coverage.

Disclaimer

The Medicare information in this handbook is for informational purposes only. If there is any difference between the information in this handbook and information provided by the Social Security Administration, which manages Medicare, the Social Security Administration governs.

Claims Process

In-network vs. out-of-network

In-network health care providers are those who have contracted with the third party administrator (TPA) or insurer and agreed to accept a certain amount as payment in full for specific covered services.

Out-of-network health care providers have no contract with the TPA or insurer. They may charge more for specific services than what the in-network providers will accept. Most Preferred Provider Organization (PPO) plans pay a portion of out-of-network claims but not at the same amount as an in-network provider. However, if you go to an out-of-network provider under a Health Maintenance Organization (HMO) plan the claim would be denied by the HMO (except in emergencies).

Plan year deductible

Before benefits are payable under your benefit plan, you must first satisfy the deductible for services. The deductible requirement applies to all services unless otherwise noted on the benefit summary of your specific plan. The plan year deductible also applies towards satisfying the out-of-pocket maximums. Once the deductible is met the coinsurance or co-payments begin.

Out-of-pocket maximums

The out-of-pocket maximum includes the deductible, co-payments and coinsurance you incur in a benefit period unless otherwise noted on the benefit summary of your specific plan. Once you and/or your family’s out-of-pocket maximum is satisfied, no additional co-payments or

coinsurance will be required for you and/or your family. This is true for the remainder of the benefit period, unless otherwise noted on the benefit summary of your specific plan.

Lifetime maximum

Your medical plan contains a lifetime maximum payment of $2 million. This is the lifetime maximum amount of benefit payments available to you and each of your covered dependents for as long as you are covered under the plan.

Premium Payments

Premium payments for active employees are generally paid through payroll deductions with the employee paying a portion and the state paying the balance of the premium amount. This process is not available for employees in out-of-pay status, so a separate billing process applies. Employees are responsible for the entire amount of their assigned portion of premium, and in some instances are responsible for the entire amount of the premium. If a premium or a portion thereof that is your responsibility has not been fully paid, any underpayment must be paid upon request regardless of the time period for which the underpayment occurred.

Out-of-pay status

If you are in out-of-pay status, the insurance carriers will direct bill you at home for the premiums due. Premiums must be paid by the due date on the billing to ensure continuation of coverage. Failure to submit payment will result in termination of coverage retroactive to the last day of coverage for which full payment was received. If coverage is terminated for non-payment of premium, you will be responsible for any claims incurred as of the termination date. Employees and their dependents that have been terminated for non-payment of premium are not eligible for continuation of coverage through COBRA.

COBRA

Under federal COBRA law, the state is required to offer covered employees and covered family members the opportunity for temporary extension of health coverage (called continuation coverage) at group rates when coverage under the health plan would otherwise end due to certain qualifying events. Each qualified beneficiary has independent COBRA election rights and has 60 days to elect continuation coverage. The 60-day election window is measured from the later of the date health plan coverage is lost due to the event or from the date of COBRA notification. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end and they cease to be a qualified beneficiary. If a

COBRA election is made within the 60-day election window and all applicable premiums are paid, coverage will be reactivated back to the loss of coverage date and pending claims will be released for payment.

Health Insurance Portability and Accountability Act (HIPAA)

Title II of HIPAA was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information by regulating the use, release and disclosure of private health information. The state contracts with health plan administrators, HMOs and other carriers to provide services including, but not limited to, claims processing, utilization review, behavioral health services and prescription drug benefits.